THE DIAGNOSIS AND TREATMENT OF GALL BLADDER DISEASE.*

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PART II.

The first installment of my article, published last month, dealt largely with what not to do in the diagnosis and treatment of gall bladder disease; this second part will deal briefly with the things which I think should be done.

THE FREQUENCY OF GALL BLADDER DISEASE

First, I should state that statistics from many sources show that from five to twelve per cent of all women coming to autopsy have gall stones. If we exclude women under fifty, the percentage is still higher. This alone would be bad enough, but we know that there must be a still larger group of men and women in the community suffering from the pre-calculous stages of cholecystitis. There would seem, then, to be no escape from the conclusion that even the careful clinician is not making the diagnosis of gall bladder disease often enough. The writer gets the idea sometimes that he is becoming mentally warped on the subject because he suspects cholecystitis in every old lady who comes in with flatulence and abdominal pain; and then along come a few autopsies or operations on his patients and he discovers a number of gall stones, the presence of which he had not even suspected.

Now, how are we going to recognize a larger percentage of these cases?

A GOOD HISTORY

First, and above everything, comes a good history. A case will often seem puzzling until skillful questioning brings out the story of one or more attacks of supposed ptomaine poisoning which really had all the earmarks of gall stone colic. The physician must remember that recurrent attacks of severe pain which perhaps waken the patient out of a sound sleep and which leave her upper abdomen sore for days afterwards are due to organic disease; they cannot be ascribed to a neurosis or to slight indiscretions in diet. In the most typical cases the pain begins in the liver region and runs up into the right shoulder blade. Often there is a constant ache on the right side. The soreness is aggravated by riding over a rough road or by reaching up on a shelf. Women perhaps will be unable to bear the pressure of their corsets in the liver region. In milder cases and in the intervals between attacks, the patients complain mainly of belching and bloating. They often feel "bilious" and get a little sallow. Only rarely are they jaundiced. Nausea, regurgitation of food and heartburn are common. Vomiting often comes during the attacks of pain.

Most characteristic and helpful is the patient's statement that although she has a fine appetite she is afraid to eat. She dreads the return of pain. Yet she will admit that what she eats seems to have little or nothing to do with the coming of an attack. She may get a bad one after a week of fasting, and later she may digest a Thanksgiving dinner without discomfort.

Several suggestive points may be mentioned. A history of a useless appendectomy shows that the symptoms were so bad that the patient was willing to do anything to get well. A history of typhoid fever, chronic sinusitis, empyema, or any other severe and prolonged infectious process is helpful because such things often leave the gall bladder damaged irreparably.

The presence of arthritis, myocarditis and certain forms of headache and dizziness is suggestive because these troubles sometimes clear up after cholecystectomy.

THE PHYSICAL EXAMINATION

This generally shows a woman between forty and sixty-five although, as our experience grows, we are going to recognize cholecystitis more and more in the twenties and thirties, and even in childhood when the trouble often begins. In subacute cases the patient gives a jump when a deep breath brings the tender liver edge down against the palpating hand (positive Murphy's maneuver). The presence of fibroids in the uterus, or other pelvic abnormalities, greatly increases the probability of finding gall bladder disease.

ROENTGEN-RAY EXAMINATION

This can help greatly in several ways. First, it may exclude the presence of other organic lesions such as ulcers and carcinomas.. Second, it may show the shadow of stones or of a thickened gall bladder on the plate. Unfortunately most of the diseased gall bladders are free from stones and so thin-walled that they will not show on the plate. Furthermore, many stones are too soft to give a shadow. Third, the screen examination often shows many suggestive things. Cardiospasm is often seen, and I am coming to think more and more of it as an indicator of gall bladder disease. The stomach is often hypertonic and overly active; and not infrequently the pyloric antrum is contracted and sharply conical in shape. There may be some gastric stasis, and it may also be apparent to an experienced observer that the gastric mucosa is dry (achyliac). The duodenal cap is sometimes deformed by adhesions or pressure, and it may also show defects in emptying. The colonic haustration is often exaggerated. The liver is not infrequently enlarged from the cirrhosis attendant upon prolonged infection of the bile ducts.

LABORATORY TESTS

Gastric analysis often shows an achlorhydria. In the first part of my paper I have explained why I think the Meltzer-Lyon test should not be used diagnostically.

TREATMENT

Like appendicitis, gall bladder disease may go on and kill the patient or it may clear up even without treatment. Once cleared up, it may leave the victim alone or it may come back at intervals until finally something has to be done. We know now that it is best and safest to take diseased appendices out. Unfortunately, we do not know

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yet what to do with the early cases of gall bladder disease. If we could only look into the future for the different individuals it would be easy. When I see women about sixty-five, emaciated, worn with suffering, anxious for an operation which they cannot well stand, I tell myself that it is my moral duty to urge the younger ones to go to the surgeon. When, however, I see a series of women about forty who have gone ten or fifteen years without attacks or much distress, I waver, and am inclined, as is the patient, to let well enough alone.

Unfortunately, it seems impossible to say when these people are really "cured" and free from the menace of their diseased bile tracts. Thus, one would think, after several attacks of gall stone colic that an interval of twenty years without troublesome symptoms would indicate a cure, but I have seen a woman in whom such a period of relief was really only an interlude. When she was sixty-one her troubles returned; a plate showed that a stone still remained, and an operation showed that a carcinoma had developed somewhere in the biliary tract.

It is hard to say whether medical treatment does much good because remissions occur so frequently and come so suddenly. Ordinarily it is well to advise a smooth, cellulose-poor diet; that is, without salads, coarse vegetables, or fruits. Some people are helped by the taking of Carlsbad salts in hot water before breakfast. Belching and heartburn are often helped by the giving of sodium bicarbonate and magnesia. Hoffman's anodyne often brings relief during attacks at night. During paroxysms of pain, paregoric, morphine and papaverin have to be used. The physician should remind the patients who are losing weight that they will probably have trouble whether they eat or not, so that they had better eat and keep their strength.

DIFFERENT TYPES

For therapeutic purposes the cases may at present be divided into six or seven groups. Medical treatment should be reserved for:

First, those who are in the early stages of the disease, with mild symptoms and long intervals of relief, whose bodies are still young and strong, and who may perhaps yet hope permanently to overcome the infection.

Second, those whose symptoms and findings strongly suggest the presence of cholecystitis but who are suffering so much from nervousness, menopausal storms, hypertension, or myocarditis that it is a question whether they would be any better off even if a markedly diseased gall bladder could be removed safely. These people must be studied carefully before any decision is made in regard to operation.

Third, those who need and want an operation but who, on account of complications, cannot undergo it with any prospect of success.

Fourth, those who have had a cholecystectomy but who still suffer. Many of these people might have gotten a perfect result if they had been put on a smooth diet after operation.

In the absence of definite contra-indications operation should be advised for:

First, those who have reached that stage of the disease in which the attacks are getting steadily worse and more frequent.

Second, those whose indigestion is severe enough to interfere with ability to work and to enjoy life. They should be the more willing to accept operation if they have an arthritis, headaches, dizziness or myocarditis, which may perhaps be cured by the removal of the infected gall bladder.

Third, those who have had their gall bladders drained and who had gotten relief, but who now return with pain and perhaps with new stones.

Finally, and this is a most important point: The surgeon must be willing to admit that at the time of operation he cannot tell a diseased from a normal gall bladder. Men of experience know that not infrequently gall bladders which, according to the history, must have been discharging stones off and on for twenty years, are found at operation to be still soft and apparently normal. If they were not full of stones the surgeon would generally pass them by as inocuous. This does not mean that I am arguing for the reckless removal of gall bladders. Far be it from me; but as Judd says, there is no doubt that in many cases if the patient is to be helped, his gall bladder must be removed on the strength of a careful history taken by an experienced man. This removal can be done with more confidence if there are no other signs of disease in the abdomen to explain the severe symptoms, and if there are adhesions about the gall bladder, an enlarged gland near the cystic duct, an enlarged liver and signs of perihepatitis and pancreatitis. I am convinced that the poor results obtained in many of the cases of operative interference for duodenal ulcer can be ascribed to the leaving behind of gall bladders which had become badly involved in the inflammatory process about the bowel.

Training in Sociology and Public Health an Essential in Medical Education—S. W. Welch, Montgomery, Ala., suggests five essentials which should be made a part of a student's medical education: (1) He needs to have a sympathetic understanding of the fundamental human problems in relation to the many complexities of modern life, and must become familiar with the trend of the best thinking along social lines. (2) He needs to know the place and function of sanitation in relation to the public welfare, the how and when and why of environmental influence on health. (3) He needs to be well grounded in the control of the communicable diseases and in bacteriology. (4) It is imperative that he should have a knowledge of hygiene, especially in its relation to the social and medical sciences which attempt to improve the race by approximating a solution of the basic problems of human existence; that is, the problems associated with the necessity for food, shelter, defense and propagation. (5) He needs to have a knowledge of psychology in its relation to conduct, with regard both to individuals and to groups, in order that he may truly educate both individuals and groups in right habits of action, by supplying motives which appeal to them.—Journal A. M. A., July 29, 1922.